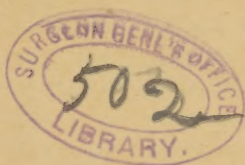


STRAUS (LEON)

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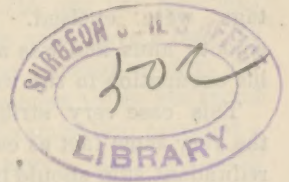
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Six Weeks' Observation in Rectal Surgery in the Practice of Dr. Joseph M. Mathews, Louisville, Kentucky, as Clinical Assistant.

BY

LEON STRAUS, M. D.



It is only in the last decade that rectal surgery has received much consideration, but because of its importance it is now classed as one of the legitimate specialties. It is recognized that much of the prominence now given this special line of surgery is due to the earnest efforts of Dr. J. M. Mathews of this city, who has worked hard and written much, in order to lift this important, but much neglected, branch out of the hands of pretenders and charlatans, whence it had drifted. I have been favored in the past six weeks in seeing and aiding Dr. Mathews operate, and I thought that it would not be amiss to record my observations. The cases herein detailed are from his private practice only, and does not include either hospital or infirmary patients.

CASE 1st. Mrs. H., aged 20. Had a history of rectal hemorrhage coming on at each stool; she was pale and anæmic, general health had suffered in consequence; she gave up society. Patient was anæsthetized, and sphincters divulsed; this revealed two capillary tumors which were seized with forceps and ligatures applied. The knife was not used at all. This case is of special interest for the reason the tumors were small, being of the capillary variety, and

not unfrequently overlooked by general practitioners and surgeons. This patient was discharged in six days, well, — no hemorrhage.

CASE 2d. Mr. H., aged 57. He had inflamed internal hemorrhoids, with considerable redundant skin around the anus. Patient was anæsthetized; sphincters divulsed, each tumor seized with forceps and ligatures applied. Two transfixions were done and two single ligatures used; all the cedematous redundant skin was included in ligatures in order to make a smooth anus. According to the literature of this subject, and the teaching of the majority of surgeons, this was a dangerous thing to do, for the reason it is said to result in stricture. This case and many others, convince me that more is to be feared from cutting too little rather than too much. This case further proves the fact that an operation, when the piles are inflamed, goes on to an uninterrupted and good recovery.

This patient had hemorrhage three hours after operation, the result of the ligature cutting through the diseased tissue; the hemorrhage was promptly checked by the skillful superintendent, of the "Norton Infirmary," by the application of *Monsell's* solution. This was a

dangerous hæmorrhagic, for the reason that it destroys the ligatures often, but fortunately did not do so in this case.

CASE 3d. Aged 30. Had internal hemorrhoids and external tags.

Patient was anaesthetized; sphincters divulsed; tumors seized with forceps; two single ligatures were applied and two transfixions were done; external tags were excised. Patient has a smooth anus and was able to return to his occupation in two weeks.

This case very strikingly illustrates the very same fact as case 2nd, viz.: all redundant skin should be removed without the fear of stricture; if left it may, and does give trouble by becoming inflamed.

CASE 4th. Aged 40. Dr. B. He said he had piles which came down, and complained of great pain on defecation; examination revealed one small pile which was complicated with ulceration, which accounts for the pain during and after action. Patient would not take chloroform. Sphincters were divulsed and thoroughly rubbed with the fingers; ulcer scraped, tumor ligated; rectum flushed with bichloride, one to 5,000 solution; T bandage applied over iodoform gauze and cotton. Patient was discharged in six days, well.

CASE 5th. Mrs., R., aged 27. Referred to Dr. Mathews for treatment. Said she had piles and bled freely at each stool, also complained of great pain after defecation; so great was the pain she said she was in the habit of coming from stool and throwing herself face-foremost on the floor until the pain ceased. Chloroform was given, sphincters divulsed, which revealed an ulcer posteriorly, and a bleeding surface anteriorly, the latter being a pathological condition not described in any work on rectal surgery that I have seen. When Dr. Mathews does an operation like this he takes up the bleeding sur-

face with a pair of forceps with large serrated edges, and includes it in a ligature, after which he gives the surrounding surface a thorough rubbing with the fingers, which relieves permanently all congestion. This patient had an uninterrupted and rapid recovery.

CASE 6th. Age —. Dr. W. Had a history of hemorrhage at stool, and complained of great pain after each action. His trouble dated back four years, latterly he was unable to attend to his duties because of pain; chloroform was given, sphincters stretched and revealed a large and irritable ulcer, together with one internal capillary pile. This condition is typical of a large class of cases where the one disease complicates the other, or the two co-exist; the tumor was ligated, ulcer scraped and superficial muscular fibers divided. Patient was out in one week, well.

CASE 7th. Aged 27. B. F. Gave a history of great suffering after each stool; had persistent constipation, a symptom so often associated with irritable ulcer, and in this case as in others, the constipation was due to the firm contraction of the sphincters and purely mechanical. Gave the patient chloroform and divulsed the sphincters; gave the ulcer a good scraping and excised the pathognomonic external tag. The patient's bowels moved the fourth day without pain. "It goes without saying, patient was delighted."

CASE 8th. Aged 40. Mr. J. O. Was referred to Dr. Mathews for treatment. He gave a history of several years of constipation; a typical case, for the reason he said he never had an action and never would without taking a purgative; he said "but for this trouble I should be in perfect health." Examination revealed a fissure just within the folds of mucous membrane of the anus. The constipation was the result of a firmly contracted sphincter, due to

the reflex irritation produced by the fissure. Patient was anæsthetized; sphincters divulsed, and cut off the characteristic tag. Patient was out the fourth day; bowels regular.

CASE 9th. Aged 38. Mr. W. He had a history of pain with slight hemorrhage; he diagnosed his case, piles, which he said came down or protruded, but could not get it back, a mistake not infrequently made by physicians. The part which seemed to protrude was an everted swollen mucous membrane, a condition frequently complicating ulcer; gave chloroform and divulsed sphincters. A large and typical ulcer was seen posteriorly; ulcer was scraped and muscular fibers divided; the everted mucous membrane was so considerable it was cut around and included in a ligature. Patient discharged in six days well.

CASE 10th. Dr. W., aged 55. Came from the Pacific Slope to consult Dr. Mathews. Had a history of constipation and complained of something coming down at stool although it did not come out. Patient took ether sul. by choice. Sphincters were divulsed; a large polyp came tumbling down and out of the rectum. The pedicle was quite large; transfixion was done, and to make assurance doubly sure as to hemorrhage, a strong ligature was applied below the transfixion, polyp cut off; pedicle returned, rectum flushed with a one to 5,000 Sol. of bichloride; dressed with iodoform, gauze and cotton; T bandage applied. Patient discharged in ten days.

CASE 11th. Mr. L., aged 26. Had a history of abscess some three or four years ago which resulted in fistula, but not in ano, and in some respects unique. One opening just above the tip of the coccyx running up the spine about 5 or 6 inches. The main sinus was cut through and quite a number of smaller lateral tracts were cut. This entire

operation was done by injecting cocaine under the skin first, and injecting it as we cut whenever the patient complained of pain. This patient made a speedy recovery, leaving city in ten days; when he called several days later his wound was almost healed.

CASE 12th. Mrs. P. Married. Age 43. Had a history of great pain at stool; so intense (to use her own language) she had as soon have a baby as an action; she was, strange to say, advised by her physician to let her rectal trouble alone. Examination revealed a very large and ragged ulcer extending from the upper border of internal sphincter to below the external sphincter in the mucous and external skin; this ulcer had existed for years; the patient had a bad cough and all the physical signs of tuberculosis; for this reason a good result was doubtful; patient was anæsthetized, sphincter divulsed, ulcer scraped and dressed with iodoform; in a few days patient had painless action; first in years. "It goes without saying" she was delighted with the result. In this case, as in all others, we divulsed thoroughly but never break the sphincters, as is advised by so many authorities.

CASE 13th. Mr. G., aged 52. Large frame and gives a history of perfect health until one year ago when he had large abscess in ischio-rectal fossa. This resulted in fistula in ano. Was induced to go to an advertising specialist. Five elastic ligatures were used by the doctor (?); the result was *five* large suppurating wounds. In this condition he came to Dr. Mathews. Patient was given chloroform; a large internal opening was found which had been overlooked by the first operator; from this a number of sinuses radiated. Each and all of them were carefully traced, thoroughly cut through, scraped and edges trimmed. The five existing

wounds were treated in the following manner: edges carefully trimmed and the bottom of each scarified. The operation was done under antiseptic precautions, and the wounds dressed with iodoform, gauze, etc., a T bandage applied. Dressings removed on fifth day. Under observation five weeks; result, a cure.

CASE 14th. Mr. F., age 30. Occupation, merchant. Complained of intense itching in and around anus; examination revealed a typical case of pruritus ani. The general habits of the patient were looked after; coffee, alcohol, beer, tobacco, etc., interdicted and a local application of pure campho-phenique applied. Ordered that bowels be kept freely open with aperients. Patient improving.

CASE 15th. Mrs. M. Young married woman; gave following history: for three years had been under treatment by an irregular, for rectal disease. He had diagnosed severe ulceration complicated by a large tumor; when asked what were the symptoms which called for such opinion, said she suffered with a "bearing down pain" all the time; only this and nothing more. An application to the rectum had been made once or twice a week for three years. An examination was made by Dr. Mathews, with the following result: no ulceration, one small internal pile, and the supposed tumor (?) was the uterus, which, by a displacement, was pushing down against the rectal walls. She was so informed and departed, happy.

CASE 16th. Mrs. D., married, age 32. Came here from the south to be delivered of a baby. The attending physician discovered that she had a close stricture of the rectum. Six weeks after childbirth she was referred to Dr. Mathews for treatment; the stricture was easily detected, being about two inches above the external sphincter

muscle. Chloroform was administered and the stricture forcibly broken to the full capacity of a rectal dilator; a fissure knife was then passed into the rectum, and the remaining fibers of the stricture cut through in three different places, down to the normal tissues of the gut. Quite a good deal of hemorrhage occurred, and the rectum was plugged with absorbent cotton, saturated with Monsell's solution. Through the center of the plug a tube was passed and allowed to remain; this tube answers a double purpose: first, it is a gauge as to the amount of blood being lost; second, it allows the passage of the gas from the bowels. The plug was removed on the third day, and the rectum syringed out with carbolized water.

CASE 17th. Harry C., age 12. A bright and well-formed boy. He complained of pain in back, and down the thighs; some lassitude; had lost a little flesh; color not good; family history first-class. Has had a dysenteric (?) discharge for several months; passes blood and mucous from the bowel; actions always strained; great tenesmus; goes to stool from three to ten times in twenty-four hours; never passes a well formed action. An examination was made and showed the lower part of rectum to be in a healthy condition. About four inches up a roughened surface could be felt, extending into sigmoid flexure. Dr. Mathews gave it as his opinion that the growth was malignant. It was ordered that the boy have the bowel thoroughly syringed with hot water, through a *Wales* rectal bougie, each morning.

At night the following deposited in the flexure:

R Fluid Hydrastis. . . .	½ ounce.
Aqua Dest.	2 ounces.

Internally large doses of subnitrate of bismuth was ordered to be taken after

each action, in small cup of boiled milk. Up to date there is no decided improvement.

CASE 18th. Mr. C., railroad man. Came in complaining of great pain in rectum; upon inspection a small abscess was discovered at margin of anus; upon the introduction of the finger the abscess could be plainly felt, extending up the rectum. An incision was made parallel with the gut and the pus evacuated. He was told that he might have a fistula sinus result. He left for the South next day.

CASE 19th. Miss G., referred to Dr. Mathews by a local physician. Upon examination a fistulous sinus was seen to begin in the left labia. A probe introduced passed directly down into the rectum, under the external sphincter muscle. The patient anæsthetized; all the tissue upon the director was divided, and several other small sinuses so treated. The edges were freely trimmed; wounds dressed with iodoform, etc. She is making good recovery.

CASE 20th. Miss A., 20 years of age. Has four fistulous openings around anus; two on right side and two on left. The inner bowel perfectly healthy save one well marked internal fistula; chloroform administered. Dr. Mathews passed a director into the one of the sinuses on the right side; it passed directly into the other opening on same side, then down into rectum. A further examination showed that the sinus extended back over coccyx into the left buttock and communicated with the sinuses on that side. The tracks on the right side were freely divided, and an incision made directly into the rectum. The edges were trimmed and the base scarified. Nothing was done on the left side at this sitting, the reason being that in this peculiar kind of fistula (horse-shoe) the danger to be feared is in dividing the muscle more than once;

incontinence might result. After several weeks the other side will be operated on. The wounds were dressed antiseptically, and are healing nicely.

CASE 21st. Mr. H., age 35. From interior town in Kentucky, gave history of rectal abscess eight months ago, since which time he has had constant discharge of pus from external sinus. Examination showed the left buttock completely undermined. An anæsthetic was given, a director passed into external opening and ran a distance of seven inches up toward the scrotum; a free incision was made; many sinuses and small cavities were divided and scarified; all edges cut off and a large wound left, which was dressed in the usual way. An irrigation of a 5000 Sol. of bichloride merc. was used during the operation. The healing process was perfect.

CASE 22d. Miss B. Referred by a physician in a neighboring State. She suffered from a rectal condition not described in the books. Externally there was a large amount of redundant skin around the anus. The attempt at an introduction of the finger revealed a hard and contracted sphincter muscle; over the muscle was a distinct rim of ulceration. This had evidently been induced by the daily efforts to put into the rectum that which did not belong in it, viz.: the redundant skin. Chloroform administered; the sphincters were paralyzed and the ulceration roughly rubbed with the fingers; the large mass of skin was then divided into segments, closely tied and cut off; much mucous membrane was included in the ligatures. An irrigation was kept up all during the operation, and the wounds dressed antiseptically. This patient suffered but little pain after the operation, although a nervous female.

CASE 23d. Miss M. A member of the *demi-monde*. Had venereal warts

around the anus. These were all cut off and Monsell's solution applied to each wound. No condylomata existed.

CASE 24th. Mr. B., Druggist, had dysentery six or eight months ago. Got better. Has eight or ten small bloody mucous discharges a day; great tenesmus and pain. He was ordered to take a teaspoonful of subnit. bismuth in cup of boiled milk after each stool. He reported in one week and said the discharges were checked, and that he was now constipated. It was prescribed that he take a dose of castor oil. Patient discharged.

CASE 24th. Mr. McC., aged 69, says he has had protruding piles for four years; within the last two weeks has had great pain at stool, and within several days past, excessive hemorrhage from rectum. Patient instructed to take large enema and allow the protruded parts to remain out until Dr. Mathews should come to operate. Upon examination, a very large, soft *polyp* was found protruding out of the anus; no piles existed; the polypus being low down and attached by a pedicle: it was caught between the fingers and a ligature thrown tightly around it and the tumor cut off.

CASE 25th. Mr. M. Living in the city. Came to the office complaining of an attack of piles. Examination showed three internal piles protruding; greatly inflamed, large oedematous roll completely surrounded the anus. He was ordered a brisk purgative, and the next day appointed for operation. He was then anesthetized, the inflamed skin cut into sections and each section made to include an internal pile; after each was tied the tissue was cut off closely hugging the base. Transfixion was practiced here. This is one of many cases of hemorrhoids operated on by Professor Mathews, while in the inflamed state. My observation has been

that they do exceedingly well, contrary to the teaching of many.

CASE 26th. Mrs. G., aged about 40. Had piles for many years; was in the habit of pushing them back after each stool; for the past week had been confined to bed from the excessive pain; nervous system shattered; she feared an operation but consented; chloroform was given and the tumors brought down, which were found to be ulcerated. A decided stripping of the epithelium could be seen just above the sphincters: thorough dilation was practiced; tumors tied and cut off; parts dressed as usual and bowels ordered moved on third day. It is the custom of Dr. Mathews to give a hypodermic injection or $\frac{1}{4}$ gr. morphine after ligating piles. None of these patients have ever complained of much pain after the operation; none of them but could have walked after forty-eight hours, with ease. They are usually discharged on the seventh day.

CASE 27th. A gentleman sent for his family physician; said he had been up the entire night suffering excruciating pain in the rectum. Dr. Mathews was sent for in consultation, and found a fish bone sticking in between the two sphincters; an effort was made to remove it by forceps, but because of pain it could not be done; a large enema was given and it passed with the faeces.

CASE 28th. Mr. B., aged 23. Had complained of, and been treated for dysentery for several months. Being put on the table, a speculum was introduced, revealing an ulceration just above the external sphincter muscle, which extended all around the gut; an incipient formation of a stricture was detected. The patient denied ever having syphilis, but confessed to a local sore about two years back; no evidence of secondary eruption, etc., was dis-

coverable. Was ordered to inject rectum once a day with the following:

R Fluid Hydrastis . . . 1 ounce.
Aqua Dest. 2 ounces.

The patient was put upon the mixed treatment for syphilis.

CASE 29th. Mr. A. Had for several years complained of an uneasy sensation in the rectum, and of radiating pains down the thighs and in the lumbar regions; had passed a good deal of mucous mixed with the natural action of the bowel; lately, blood has been passed freely, sometimes as an admixture, sometimes alone; faeces passed in small balls; never well formed actions. Upon examination no tumor could be found in the abdomen. Inguinal glands slightly enlarged. Patient has lost fifty pounds of flesh in two years; bad color. Chloroform administered; rectum freely divulsed; large ulcer just above sphincter; no stricture above. Dr. Mathews thought that local trouble in rectum might account for symptoms, though suspects cancer. Rectum and sigmoid flexure washed daily with boric acid solution. It will be seen that much is expected in this case by the thorough divulsion of the sphincters, because not only of the existence of an ulcer, but of the pathological changes in the muscle. I wish to emphasize here that it is never the custom of Dr. Mathews to *break* the muscle, as advised by so many authorities.

CASE 30th. Mr. R., aged 30. Consulted Dr. Mathews, saying his rectum was giving him great trouble, especially through the day he had incessant burning, but so soon as he got into bed at night he got comparative relief. Examination revealed a beautiful case of *czema erethematosa*; he had been using all sorts of salves in the hope of getting cured, but was not in the least improved; he was given the following:

R. Bismuth Subnit.

Hydrarg. Chlor. Mite. 55 ½ ounce.

Boric Acid. 1 drachm.

Apply often, and leave off the application of all oleaginous substances; absolute dry dressing. Patient much improved.

CASE 31st. Dr. B., aged 60. Had a gigantic abscess, involving the whole of left buttock; according to Dr. Gerster it was a typical, acute progressive phlegmon, with all of the usual train of constitutional symptoms; in other words, septic infection. Patient was prepared for an operation; a free incision was made at most dependent part in order to assist drainage. After the incision was made the finger was introduced and all loculi were broken down, and abscess cavity thoroughly irrigated with a solution of bichloride of one to 5,000; then a dressing of moist bichloride and absorbent cotton with oiled silk on outside, with a T bandage. Patient commenced to improve at once and is now able to be up; of course he will have a complete fistula in ano.

REMARKS.

I have often noticed in reading the literature on the subject, it is said that antiseptic surgery is of little account around the rectum; to this statement I must dissent. The splendid results obtained by Dr. Mathews, I believe to be greatly due to his careful observance of antiseptic, or aseptic, precautions. It may be of interest to my readers to explain his method.

All of his foreign patients are sent to a private infirmary. It is best to speak of these, for the reason that patients in private homes cannot be managed so well.

A general bath is immediately given and the patient ordered to take a free purgative; after this has freely acted, an enema is given by the nurse and the

patient carried to the operating room. Two solutions are in readiness: Sol. Bichlor. Hydgr. 1-5000, and 30 per cent. sol. of carbolic acid; into the latter the instruments are dropped, and the mercuric sol. used for the hands and for irrigating purposes. The hands and arms of the operator and all assistants are scoured in hot water and soap, and the operator begins. The surgical assistant takes his position by the side of Dr. Mathews, and a nurse holds the tube of the irrigator; another stands on the opposite side to aid in keeping the parts in position. In cases of internal hemorrhoids, Dr. Mathews' own operation is done, which differs from that of Mr. Allingham, in that he does not cut in the imaginary, or so-called sulcus. He makes his first cut in the true skin surrounding base of the tumor, and thereby at one cut does away with all redundant skin. A stout thread is placed in the cut and tied as tightly as possible; the tumor, including the skin, is then cut away. Each pile is treated in like manner. I have seen him go all around the anus in this manner, cutting away a vast deal of flesh, and no contraction has ever resulted, which makes me think that

the apprehensions of writers are purely imaginative who speak of the dangers of contraction after the operation. Indeed, I am persuaded, after seeing Dr. Mathews do many of these operations that the more integument you cut away the better the patient will do. It is very seldom that a vessel is cut; if it is, time is taken to either twist or tie. All tumors secured, the irrigation is now suspended, the wound dressed with iodoform, — iodoform gauze, sublimated cotton, a T bandage applied and the patient put to bed. This dressing is allowed to remain on for three days, when the wounds are re-dressed.

I have failed yet to see a drop of pus when the dressing has been taken off of any wound, fistula, piles or what not. After the operation for piles, the patient suffers but little pain, and is usually discharged on the seventh day. The sphincter muscles are freely divulsed before beginning the operation. The anæsthetic preferred by Dr. Mathews is chloroform, though I have seen him administer ether twice lately. A small drink of whisky is usually given the patient just before inhaling chloroform.

